same direction in which you have rotated the occiput. When, as is most commonly the case, the occiput is turned to the right rear; the back of the left shoulder will be found above the pubes; with the external hand push the shoulder towards the mother's left side. If you succeed in pushing the shoulder over, the occiput will not slip back; if you do not succeed in moving the shoulder the occiput will very readily, as a rule, slip to the rear. If you are not able to push the shoulder with the external hand, it is sometimes a comparatively simple matter to push the internal hand on past the head and rotate the body of the child in such a way as to bring the shoulder in its right position, with the back of the child towards the mother's front, instead of towards the right side. If you are not quite certain that you have got the body of the child in the right position, and especially if you find the slightest tendency in the occiput to slip backwards, try and hold it in position until you have introduced one blade of your forceps. This will generally keep the occiput to the front until you have applied the second blade.

If you have applied the forceps deliver in the ordinary way, not too rapidly—at the same time without losing any unnecessary time.

I shall not here discuss the various methods of rotating the occiput to the front which have been described; I should simply say to you if you know any better method than that which I recommend employ it. Years ago I was not successful in all cases in pushing the occiput to the front with my two fingers, as recommended by many authorities abroad, and especially James Ross, sr., and Algernon Temple, of Toronto.* Having a small hand I often found it much more easy and much more satisfactory to introduce the hand within the vagina and employ it in rotating. So far as I know Batailliard was the first who definitely described this method of manual rotation of the occiput forwards. During the last few years this method has been employed by a fair number of accoucheurs in the United States and Canada.

I do not intend to refer to any further extent now to difficult occipito-posterior positions, but I may say briefly that I consider that in the great majority of cases the most difficult of such positions are those which occur in connection with dry labor.

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*Since reading this paper I have learned that my reference to Dr. Algernon Temple is not correct. Instead of using one or two fingers, as I have intimated, he anaesthetized the patient, and then introduced whole hand into vagina, seized the head between the points of the fingers and thumb in the interval between pains, and rotated the occiput forward. He described this procedure in October, 1887.